HIPAA Requirements Document -DRAFT

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 imposed new standards on the exchange and use of health information for some entities. The requirements are found in the Administrative Simplification provisions at 42 USC 1320(d) and implementing regulations at 45 CFR Sections 160, 162, and 164. The entities that are regulated by HIPAA and the requirements for standardized transactions are outlined below.

Health Plan

Health Plan definition: an individual or group plan that provides, or pays the cost of, medical care. Specifically named health plans include Medicaid, Medicare, SChip. *Health plan exception*: programs that pay excepted benefits and government funded programs that are not specifically listed, whose principal purpose is other than providing, or paying the cost of, health care; or whose principal activity is the direct provision of health care to persons or the making of grants to fund the direct provision of health care to persons. §160.103. See also exceptions at 65 CFR 82479, 82578.

Transaction Regulation Requirements Overview: Standards are required for the following transactions, conducted with another entity or within the same covered entity:

- health care claims or equivalent encounter information,
- health care payment and remittance advise,
- Coordination of benefits,
- health care claim status,
- health plan enrollment and disenrollment,
- Eligibility for a health plan,
- health plan premiums payments
- Referral certification and authorization
- First report of injury
- Health claims attachments
- Other transactions as prescribed by the Secretary. *42 USC 1320d(2); §160.102; §162.923; FR 50313*

Health plans must conduct a transaction as a standard transaction if an entity requests it. *§162.925*

Fax imaging and voice response [and paper] transmissions are not subject to the HIPAA transactions standards but may have to meet privacy and security standards. Health plans may continue to offer these services, however, they must still be able to accept and send the HIPAA standard transactions. *HHS FAQ Answer 12/28/00*

In addition to the standard, a health plan can offer a direct data entry option which must use the applicable data content and data condition requirements, but

is not required to use the format requirements of the standard. No incentive can be offered to a provider to use this option. *§162.923(b), §162.925.*

Health plans can choose to use a business associate (e.g. clearinghouse) perform some or all transactions on their behalf, but must required that the business associate comply with HIPAA and require any agent or subcontractor to do so. §162.923(c)

A health plan must accept and promptly process any standard transaction that contains codes that are valid, as provided in subpart J of this part. *§162.925(c)*

A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction. *§162.925*

A health plan may not reject a transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information). *§162.925*

A health plan must utilize only the code sets named in the standard and valid at the time the health care is furnished for medical codes, and valid at the time the transaction is initiated for non-medical codes. *§162.1000*

A health plan must not enter into a trading partner agreement that will do any of the following: *§162.915*

Change the definition, data condition, or use of a data element or segment in a standard.
Add any data elements or segments to the maximum defined data set.
Use any code or data elements that are either marked not used in the standard's implementation specification or are not in the standard's implementation specification(s).
Change the meaning or intent of the standard's implementation specification(s).

Sponsor

Sponsors are not defined in the regulation, but are defined in the implementation guide and discussed in numerous places in the official comments to the transactions and privacy regulations.

Sponsor definition: the party that ultimately pays for the coverage, benefit, or product. Can be employer, union, government agency, association, or insurance agency. In contrast, a health plan is the party that pays claims and/or administers the insurance benefits. Health plans can be insurance company, HMO, PPO, government agency, or other contracted organization. 834 Implementation Guide.

Transaction Regulation Requirements Overview: Sponsors are generally not covered entities: "We recognize that entities that are not covered under HIPAA, such as sponsors of health plans, including employee welfare benefit plans, are not require to use the HIPAA standards" …Vol. 65 CFR 50337.

However, if the entity is otherwise covered, the fact that it performs sponsor functions does not except it from HIPAA, for example: A State Medicaid program is acting as a sponsor and is excepted from the HIPAA standard requirements only when purchasing coverage for its own employees. The state Medicaid program is not acting as a sponsor when enrolling Medicaid recipients in contracted managed care health plans, and this is not excepted from the law. Vol. 65 CFR 50338. A "sponsor", when administering a public benefit program, and paying for medical care through premiums meets the definition of a health plan. If the entity is covered, sponsor transactions include enrollment and premium payments, which must be conducted in accordance with the standard. See requirements under Health Plan for transaction standards.

Health Care Provider

Health care provider definition: any person or organization who furnishes, bills, or is paid for medical or health services, or health care in the normal course of business. To be a covered entity under HIPAA, a health care provider must also transmit any health information in electronic form in connection with a standard transaction. §160.102 and §160.103.

Transaction Regulation Requirements Overview: Covered health care providers may choose to continue to send transactions via paper, fax, voice-response, or direct data entry if offered by the payer. These transmission modes do not have to be HIPAA compliant (direct data entry must conform to data content but not format). §162.923

Any transactions that the covered provider conducts electronically must be conducted in a HIPAA compliant manner or sent to a clearinghouse for translation into HIPAA standard. §162.923

A health care provider has the right to request that a health plan conduct any covered transaction electronically. §162.925

A health care provider may send a standard transaction with any or all standard data elements contained within that transaction and a health plan may not reject it on the basis that it contains elements not needed. §162.925

See requirements under Health Plan for transaction standards.

Clearinghouse

Clearinghouse definition: a public or private entity, including a billing service, repricing company community health management information system, etc. ...that does either of the following functions: (1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction (2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity. §160.103

A clearinghouse must perform the functions of format translation or data conversion to be covered under HIPAA. 65 CFR 50319.

Transaction Regulation Requirements Overview: For each covered transaction a clearinghouse performs, it must translate data in compliance with the standard. §162.900.

A clearinghouse acting on behalf of a health plan may not charge any fees or costs in excess of normal telecommunications costs to the trading partner of the health plan. §162.925.

See requirements under Health Plan for transaction standards.

Business Associate

Business associate definition: are persons or entities who, on behalf of a Covered Entity, perform or assist in an activity involving use or disclosure of individually identifiable health information or any other function or activity regulated by the HIPAA rules or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services where such services involve disclosure of individually identifiable health information. §160.103

Transaction Regulation Requirements Overview :

Business associates must comply with regulations applicable to the functions it performs for the covered entity and require any agent or subcontractor to comply. §162.923.

See requirements under Health Plan for transaction standards.